MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-042932 STATE FILE NUMBER

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 1358

DO NOT WRITE ON THIS STUB — AMENDED

VS 300 Rev. 4/59

FILED DEC 2 1963

1. PLACE OF DEATH
a. COUNTY: Buchanan
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Joseph,
Length of stay in 1b: 10 yrs.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Meth. Hosp. & Med. Center
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Buchanan
c. CITY OR TOWN: St. Joseph,
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 1308 Jules Street
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First ELMA Middle GLEE Last D'ANDREA

4. DATE OF DEATH: Month November Day 21, Year 1963

5. SEX: Female

6. COLOR OR RACE: White

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: May 3, 1905

9. AGE (last birthday): 58
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (City and state or country): Macedonia, Iowa

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Samuel T. Parks

13b. MOTHER'S MAIDEN NAME: Olive Martha DeBolt

14. NAME OF HUSBAND OR WIFE: Joseph D'Andrea

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Mr. Joseph D'Andrea-St. Joseph, Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Delayed irreversible hypovolemic shock — onset 12 hr post op
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Subacute & chronic Cholecystitis Cholecystectomy & T Tube Drainage Common Duct
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: 28 hrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Mitral & Tricusp. Cardiomegaly Moderate

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from Jan 7 19 57 to Nov. 21, 1963 and last saw her him alive on Nov. 21, 1963
Death occurred at 9:20 AM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): C. E. Senor M.D.

22b. ADDRESS: St. Joseph Mo

22c. DATE SIGNED: 11-27-63

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: Nov. 23, 1963

23c. NAME OF CEMETERY OR CREMATORY: Macedonia Cemetery

23d. LOCATION (City, town, or county) (State): Macedonia, Iowa

24. FUNERAL DIRECTOR ADDRESS: Meierhoffer-Fleeman Inc., St. Joseph, Mo.

25. DATE RECD. BY LOCAL REG.: Nov. 27, 1963

26. REGISTRAR'S SIGNATURE: Mrs. Clark Hordell

(Licensed Embalmer's Statement on Reverse Side)

C. E. Senor, M.D. MEDICAL CERTIFICATION

BY AFFIDAVIT OF DOCUMENT

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.	SHOULD READ	INSTEAD OF	DATE AMENDED
1	5117		
2	5117		
3	2		
4	1		
5	1		
6			
7	1		
8	2		
9	585X		
10			
11			
12	2-0		
13	1-0		

USE BLACK INK OR TYPEWRITER RIBBON

Permit issued 11-22-63

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Raymond N Tracy

Licensed Embalmer No. 5147

P. O. Address St Joseph Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.